FY 2003 Annual Report
on Tribal Consultation and Budget Summary

Centers for Disease Control and Prevention (CDC)
Agency for Toxic Substances and Disease Registry (ATSDR)

Report

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PART I:

TRIBAL BUDGET CONSULTATION ACTIVITIES

A. FY 2003 TRIBAL BUDGET CONSULTATION ACTIVITIES

CDC participated in the 5th Annual DHHS Tribal Budget Consultation Meeting held May 6, 2003 in Washington, D.C. The primary recommendations for CDC related to: a) provision of technical assistance about administrative procedures for CDC grants and developing competitive applications; b) infrastructure development for homeland security, participation in preparatory activities, and direct access to homeland security funds; and (c) greater participation of American Indian/ Alaska Native (AI/AN) students from TCUs in CDC/ATSDR internships and other training programs. Subsequently, CDC has examined existing AI/AN-focused activities and is actively pursuing innovative ways to expand and improve current efforts. In October 2003, CDC published the CDC/ATSDR Federal Assistance Funding Book (FAFB) to assist tribes and other potential applicants in accessing and applying for funding opportunities at CDC/ATSDR (http://www.cdc.gov/od/pgo/funding/FAFBG.pdf). In addition, CDC has standardized language in its program announcements to specifically include tribes and tribal organizations wherever appropriate and permissible. Within the FAFB, "eligibility" is now defined as:

> "The status an entity must possess to be considered for a grant. Authorizing legislation and programmatic regulations specify eligibility for individual grant programs and eligibility may be further restricted for programmatic reasons. In general, assistance is provided to nonprofit organizations, including faith-based and community-based entities, State and local governments, their agencies, Indian Tribes or tribal organizations, and occasionally to individuals. For-profit organizations are eligible to receive awards under financial assistance programs unless specifically excluded by legislation."

In September 2003, CDC senior staff responded to a request from tribal constituents to conduct a workshop presentation at the National Indian Health Board's (NIHB) Annual Consumer Conference in St. Paul, MN. During this workshop, CDC staff presented an "Overview of the Federal Budget Process – CDC", and conducted a question and answer session for tribal attendees. Specific reference materials and a graph depicting the timeline for activities were also distributed.

B. FISCAL YEAR TRIBAL CONSULTATION ACTIVITIES

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CDC

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- Diversity in Action
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HHS

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- AHRQ National Healthcare Disparities Report 2003

Throughout FY 2003 CDC continued its efforts to systematically engage tribal partners in discussions relevant to its Tribal Consultation Initiative and ongoing programs in Indian country. Between January and August 2003, CDC's Office of Minority Health (OMH) produced 10 Executive Summaries from the CDC Regional Tribal Consultation Sessions held in 2002. Each Summary was reviewed and cleared by the appropriate Area Health Board hosts and subsequently shared with all tribes in the Health Boards' region. In September 2003, the National Indian Health Board invited CDC to update tribal representatives on the status of the CDC Tribal Consultation Initiative. With assistance from the American Indian Higher Education Consortium (AIHEC), invitations were issued to all federally recognized tribal leaders, regional and national AI/AN Health organizations, urban Indian health programs, and tribal colleges and universities (TCUs) to attend a special plenary session at the NIHB Annual Consumer Conference in St. Paul, MN. Copies of the 10 Executive Summaries, plus a comment worksheet, were broadly distributed to tribal governments and organizations prior to the conference. A similar session was conducted at an annual meeting of the National Council on Urban Indian Health in October. At each session, CDC staff reviewed its consultation activities and progress to date, and described the proposed next steps CDC would be taking to complete the process of institutionalizing a Tribal Consultation Policy. After each presentation, tribal representatives actively participated in discussion sessions with CDC staff. Tribal leaders emphasized the importance of effectively following through with commitments to finalize a tribal consultation policy and institutionalize an action plan that will allow ongoing, meaningful tribal input into CDC policy development and budget formulation activities that have bearing on Indian country. Early in 2004, CDC will re-examine its progress in responding to the extensive tribal input received during fiscal years 2002 and 2003.

These activities (collectively termed the "CDC Tribal Consultation Initiative") will ultimately establish the mechanisms and procedures by which CDC will formally engage in tribal consultation activities on an ongoing basis. To ensure continued input from, and interaction with, tribal leaders during this process, CDC's Senior Tribal Liaisons actively participated in nine of the ten DHHS Regional Tribal Consultation sessions during fiscal year 2003. Discussions with tribal representatives also continued on the programmatic level, as highlighted in Part II, #2 below. For examples of CDC efforts to facilitate and strengthen interactions between state health departments and tribal governments or Indian organizations, please also see Part II, #2 below. Collaborative efforts with other Federal agencies are also noted in Part II, #2 (Senior Policy Workgroup) and CDC continues to actively support the Secretary's Intradepartmental Council on Native American Affairs (ICNAA).

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PART II:

DIVISION ACTIVITIES TO ADDRESS TRIBAL PRIORITIES

1. FUNDING AND RELATED ISSUES

Funding for prevention activities is one of CDC's highest priorities and the majority of CDC efforts involving AI/AN populations fall within this area. CDC is working with tribal governments and organizations, Alaska Native corporations, urban Indian health centers, Indian Health Service (IHS), state health departments, academic institutions, and others to promote and facilitate prevention efforts in AI/AN communities through various mechanisms, including grants and cooperative agreements; federal intra-agency agreements; training; tribal consultation; technical assistance; and direct assistance. In FY 2003, CDC awarded extramural funds to nine tribal governments, nine tribal health boards, five Alaska Native health corporations, three urban Indian health centers, and seven AI/AN-operated organizations. Awardees are located in fifteen states across the country. Total funds committed through these extramural funding mechanisms exceeded $14 million; an additional $2.4 million went to academic

programs and state health department programs that benefit AI/AN populations. The following are examples of CDC's ongoing efforts to fund prevention and other critical public health activities in Indian country:

National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

Steps to a HealthierUS

In FY 2003, the Steps to a HealthierUS Cooperative Agreement Program funded the Inter-tribal Council of Michigan to implement community-focused initiatives to reduce the burden of asthma, diabetes, and obesity.

Through the Steps to a HealthierUS Cooperative Agreement Program, HHS agencies, including CDC and IHS, are committed to providing and tailoring culturally appropriate technical assistance for the implementation and evaluation of community-based initiatives in funded tribal consortia. Technical assistance will include ensuring collaboration with key partners, facilitating the sharing of resources, results, and lessons learned, making available the staff, expertise, and evidence-based resources of HHS agencies to assist in areas of surveillance and epidemiology, community assessment and planning, community mobilization, partnership development, monitoring program performance outcomes, data management, and program sustainability.

REACH 2010

Racial and Ethnic Approaches to Community Health (REACH) 2010 is a demonstration program to support community coalitions in the design, implementation, and evaluation of unique community-driven strategies to eliminate health disparities. The Eastern Band of Cherokee Indians (North Carolina), the Oklahoma State Department of Health (focusing on American Indian Tribes), and the National Indian Council on Aging, Inc. (New Mexico), are funded as part of the REACH (Racial and Ethnic Approaches to Community Health) 2010 Demonstration Program and the Elderly REACH Program (projects funded through REACH with a specific focus on the elderly). Additionally, CDC has awarded five cooperative agreements to fund core capacity projects targeting American Indians and Alaska Natives (AI/AN). Four organizations that address the health needs of AI/AN people: Albuquerque Area Indian Health Board, Inc. (New Mexico); Association of American Indian Physicians (Oklahoma); Chugachmiut, Inc. (Alaska); and United South and Eastern Tribes, Inc., (Tennessee) and one tribe, Choctaw Nation of Oklahoma, were awarded funds to build core capacity to address health disparities from the "Healthy People 2010" priority areas of Immunizations, Infant Mortality, Breast and Cervical Cancer, Cardiovascular Diseases, and HIV/AIDS. These organizations are assisting tribes in building infrastructure for scientific capacity and surveillance, developing culturally competent health promotion and disease prevention strategies, providing training and technical assistance, and facilitating networking and partnership development through the use of Community Action Plans.

National Diabetes Prevention Center

To address the serious epidemic of diabetes in American Indians, CDC established the National Diabetes Prevention Center (NDPC) in Gallup, NM. The purpose of the NDPC is to prevent diabetes and its complications through culturally appropriate and scientifically sound participatory, community-based prevention research in AI/AN populations. The goals of the NDPC are to 1) identify "what works best" in diabetes prevention by testing and evaluating new and existing models of diabetes prevention and then sharing the outcomes with others; and 2) provide training and education activities according to community needs and priorities, as well as to provide the latest information and techniques on diabetes and diabetes prevention through conferences, seminars, and technical assistance.

To support its community-based prevention research efforts, the NDPC provides funds to the American Indian Higher Education Consortium (AIHEC), a collaboration among tribal colleges and universities (TCUs) representing 34 colleges in the U.S. and one in Canada. AIHEC provides a unified voice for the tribal college network that gives American Indian students access to quality higher education programs. Through "Honoring Our Health: Tribal Colleges and Communities Working to Prevent Diabetes," the National Diabetes Prevention Center supports AIHEC in building capacity for promoting and sustaining innovative diabetes prevention programs within TCUs. The NDPC funding (approximately $1 million/year) supports program development and technical assistance in the public health approach to diabetes education and program evaluation.

National Diabetes Education Program (NDEP)

The National Diabetes Education Program (NDEP), a joint initiative between CDC and NIH, has created an extensive partnership network to mobilize public and private sector organizations to work with the NDEP to improve the way diabetes is treated. An American Indian Workgroup was formed to assist with the development of culturally appropriate TV, radio, and print ads for American Indian communities. With input from tribal leaders and community members, the campaign message became, "Control your Diabetes for Future Generations." In addition, the Association of American Indian Physicians (AAIP) was selected by CDC to help disseminate campaign materials. The American Indian Workgroup is also developing a new campaign focused on youth.

Diabetes Prevention and Control Programs

CDC supports diabetes prevention and control programs (DPCPs) in all 50 states, Washington D.C. and eight territories to reduce the complications of diabetes. DPCPs with large American Indian populations partner with tribes to conduct health system, health communication, and community-based interventions. For example in Montana, the diabetes program is actively working with IHS, Indian tribes and other partner organizations in the State to improve surveillance and diabetes care and prevention efforts at the local level, and to provide unique training to meet the needs of Indian and non-Indian communities.

Tobacco Prevention and Control

To reduce tobacco related disparities in AI/AN communities CDC provided technical assistance and financial support to seven (7) Tribal Support Centers (TSCs), and the Northwest Portland Area Indian Health Board (NPAIHB). NPAIHB is one of nine National Networks designed to develop community networks around tobacco control in targeted communities. It is also funded as one of seven (7) Tribal Support Centers. The other TSCs are: Aberdeen Area Tribal Chairmen's Health Board; Alaska Native Health Board; California Rural Indian Health Board; Intertribal Council of Arizona; Muscogee Creek Nation; and the Intertribal Council of Michigan. The TSCs work with tribal governments and organizations to provide them with appropriate tobacco control initiatives.

Cancer Prevention and Control

In FY 2003, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funded 13 tribal governments and organizations. NBCCEDP has helped to increase mammography use by women aged 50 years and older by 20 percent since the program's inception in 1991. NBCCEDP targets low-income women with little or no health insurance and has helped reduce disparities in screening for women from racial and ethnic minorities. Approximately 50 percent of screenings provided by the program were to women from racial or ethnic minority groups. Of that 50%, approximately 6.8% are AI/AN women.

NBCCEDP helps low-income, uninsured, and underserved women gain access to lifesaving screening programs for early detection of breast and cervical cancers. The success of NBCCEDP depends on the complementary efforts of a variety of national organizations and other partners. CDC has joined with many such partners to help strengthen and maintain the infrastructure needed to implement NBCCEDP and other health programs targeting underserved women. One partnership effort involves the Bureau of Primary Care (a division of the federal Health Resources and Services Administration [HRSA]) and the community health centers that it funds; the Institute of Healthcare Improvement; the National Cancer Institute (NCI); CDC; and other organizations. This project is focused on increasing screening for breast, cervical, and colorectal cancers within the populations served by community, migrant, and homeless health centers, as well as on improving follow-up for patients with abnormal screening results. Health center personnel are learning how small, incremental changes in clinic practices (e.g., linking screening to non-routine clinic visits) can lead to improved health outcomes for the populations they serve. They are being taught how to plan and pilot-test such changes as well as how to assess and use test results in implementing effective changes.

Another important CDC partner, Avon, makes available about $5 million every year to help community-based organizations recruit women for breast cancer screening. During 2003, Avon is working to improve links between these organizations and NBCCEDP grantees. Also, through the Avon-CDC Foundation Mobile Access Program, a grant of more than $4 million will fund at least four mammography vans to expand services for medically underserved women through NBCCEDP.

NBCCEDP grantee organizations in many states have joined with nontraditional partners, including Native American tribal leaders, councils on aging, and church groups, to offer education and outreach in community settings. Diverse partners and varied intervention strategies have successfully brought screening services to women living on American Indian reservations and in rural and inner-city areas.

For example, with grants from NBCCEDP and added support from Avon and the Susan G. Komen Foundation, the Native Women's

Wellness Program of the South Puget Inter-tribal Planning Agency has steadily expanded its outreach to women in the five tribal communities of Washington State. Native American outreach workers and tribal health care providers have built relationships of mutual trust and respect with these women, and their work continues to increase the number of women who receive screening through this program.

The National Comprehensive Cancer Control Program (NCCCP) is a federally-supported program that integrates a range of activities to develop a coordinated approach to reduce the incidence, morbidity, and mortality of cancer through prevention, early detection, treatment, rehabilitation, and palliation. In FY 2003, CDC expanded NCCCP adding 26 new programs. With $12 million this year, CDC will support 51 comprehensive cancer control capacity building programs across the United States, including 5 tribes and tribal organizations.

Also in FY 2003, DCPC posted Program Announcement #03050 - National Organization Strategies for Prevention, Early Detection or Survivorship of Cancer in Underserved Populations. Eight organizations were awarded funds to assist national organizations in the development of health programs and cancer prevention and control infrastructure enhancement to deliver cancer education and awareness activities for individuals who may be underserved, uninsured or underinsured, at risk, or of racial/ethnic minorities. In addition, CDC agreed to assist established national programs in developing and disseminating current national, state, and community-based comprehensive information on cancer prevention, early detection, or survivorship. This project includes facilitating the exchange of expertise and coordination of program efforts related to cancer prevention and control among a variety of public and private not-for-profit agencies at the national level. Minority populations referenced in the program announcement included but were not limited to American Indian/Alaska Natives. Of the eight organizations that were funded, two have specifically stated that their efforts will address this population.

WISEWOMAN

The WISEWOMAN program, a sister program to the NBCCEDP, offers additional preventive health services to the same women targeted by the NBCCEDP. Preventive health services through WISEWOMAN include hypertension and cholesterol screening along with culturally appropriate behavior or lifestyle interventions, including dietary and physical activity interventions for the target population. In FY 2003, CDC awarded cooperative agreements through a competitive process to two tribal organizations in Alaska for the WISEWOMAN project. These organizations are the Southcentral Foundation, and the SouthEast Regional Health Consortium.

Prevention Research Centers

CDC's Prevention Research Centers Program supports the joint efforts of academic health centers, public health agencies, and community partners in conducting applied research and practice among underserved populations. Two of the 28 Prevention Research Centers (PRCs), the University of Oklahoma and the University of New Mexico, focus exclusively on American Indian populations. The research portfolios of three other centers, the University of Arizona, University of North Carolina at Chapel Hill, and the University of Washington at Seattle, include projects among American Indians or Alaska Natives. The centers collaborate with tribal governments, schools serving American Indians, the Indian Health Service (IHS) and Bureau of Indian Affairs, local agencies, IHS clinics, and other organizations. Each PRC depends on one or more community advisory council to ensure AI/AN involvement in participatory research, evaluation, education, training, and practice.

Preventive Health and Health Services Block Grant

CDC's Preventive Health & Health Services (PHHS) Block Grant program funds 2 Indian Tribes, the Kansas Kickapoo Tribe and Nebraska Santee Sioux Tribe. The Kickapoo use PHHS Block Grant dollars to fund youth programs, while the Santee Sioux use funds to support Emergency Medical Services.

National Center for HIV, STD, and TB Prevention (NCHSTP)

Building Capacity for HIV Prevention

In 2003, NCHSTP's Division of HIV/AIDS Prevention (DHAP) funded the Inter Tribal Council of Arizona (ITCA) to enhance regional community mobilization for AI/AN HIV prevention programs among 19 tribes located in Arizona, Nevada, and Utah. The goal is to improve delivery and effectiveness of HIV prevention services for AI/AN tribes, organizations, and urban health centers in the three states. ITCA maintains a task force in Arizona and Nevada and a work group in Utah to prepare AI/AN persons to participate in State HIV Community Planning Groups. ITCA also provides Native American Red Cross Instructor Training in HIV Prevention for adults and youth, including "peer leader" training for youth. Finally, ITCA conducts training in grant writing, needs assessments, HIV counseling and testing, and cultural competency.

The National Minority AIDS Council was funded by NCHSTP/DHAP in FY 2003 to develop organizational infrastructure to support HIV prevention in AI/AN communities.

Also in FY 2003, NCHSTP/DHAP supported the National Native American AIDS Prevention Center (NNAAPC) to provide technical assistance to AI/AN and Native Hawaiian entities for enhancing and improving the delivery and effectiveness of HIV prevention interventions; strengthening community capacity for HIV prevention; and strengthening HIV prevention community planning. NNAAPC has provided general capacity building assistance, including community planning services, HIV prevention curriculum development, and HIV prevention intervention design, implementation, and evaluation. NNAAPC has also provided the following specific capacity building assistance: HIV prevention for gay/bisexual AI/AN men, including development of a curriculum for HIV prevention education; assistance to increase parity, representation and inclusiveness of gay/bisexual AI/AN men on community planning groups; HIV prevention among and assessment of the prevention-related needs of young AI/AN men who have sex with men; and prevention among HIV-seropositive AI/AN men.

HIV Prevention Education Programs

The Alaska Native Health Board (ANHB) is a community-based organization that aims to increase public awareness throughout Alaska about the need for HIV testing and for a continuum of care for HIV-infected individuals, and to increase HIV testing among AI/AN people. In FY 2003, NCHSTP/DHAP funded ANHB to prepare rural communities for HIV testing and to provide education to and mobilize communities for HIV prevention. The program accomplishes these goals by providing culturally relevant prevention media; urban and rural outreach, education, and awareness campaigns; and by disseminating prevention technologies. In FY 2003, ANHB completed a documentary "Breaking the Silence," that describes the effect of HIV/AIDS on an Inupiat family living in a remote Native village in Alaska.

The Indigenous Peoples Task Force was funded in FY 2003 to provide education to reduce the transmission of HIV/AIDS and other STDs among at-risk AI/AN youth between the ages of 13 and 19 years in Minnesota through a Peer Education Program. In this program, AI/

AN youth are trained to use a curriculum which incorporates traditional AI/AN spiritual concepts, values, and practices. They then conduct peer education sessions in schools (urban and rural/reservation), and at youth conferences and community programs, and through other social service agencies. Youth who participate in the Summer Native Arts Prevention Program develop plays on the subject of HIV/AIDS and STDs which they perform for peers.

HIV Counseling and Testing Services

NCHSTP/DHAP supports the Native American Community Health Center of Phoenix, Arizona, to provide HIV prevention education, support for behavior change and referrals to prevention case management and social services, as well as mobile counseling and testing services to AI/AN persons who are at high risk of acquiring HIV infection, or who have been diagnosed with HIV or AIDS.

NCHSTP/DHAP supports the Native Family Resource Center to offer HIV counseling and testing and culturally appropriate prevention education and case management to AI/AN clients in the Winnebago Service Area in Iowa and Nebraska. The Resource Center also collaborates with other health service providers in the Area to design, implement, and evaluate HIV prevention interventions. The primary target population is mothers with or at risk for HIV infection.

Comprehensive STD Prevention Systems (CSPS) Grant

NCHSTP's Division of STD Prevention funds 65 project areas including 7 cities and 8 territories for designing, implementing, and evaluating high quality, comprehensive interdisciplinary state and local STD prevention plans, and for integration of STD/HIV prevention activities. The comprehensive services are targeted to prevent STDs among at-risk populations, including AI/AN and other minorities. CSPS awards include supplemental funds for Infertility Prevention Programs (IPP) and for Syphilis Elimination efforts. IPP funds support expansion of chlamydia and gonorrhea screening and treatment efforts at traditional and nontraditional health care settings for adolescent and young adult women 25 years old and younger. Chlamydia and gonorrhea are two leading causes of infertility among young women. Syphilis Elimination funds are provided to assure that the necessary infrastructure is in place to carry out the goals of syphilis elimination, including development of individual state plans (including behavior change, screening, diagnosis, treatment and follow-up) that must be in place to assure the reduction of early and congenital syphilis.

Infertility Prevention for AI/AN

NCHSTP/DSDTP continued support in FY 2003 for the "Stop Chlamydia!" project, which aims to lower Chlamydia infection rates and obtain comprehensive information about Chlamydia infection within Northwest AI/AN communities. The Stop Chlamydia! Project collects surveillance data from participating tribes and analyzes the information for distribution to participating clinics. The project also provides technical assistance to support STD prevention programs as well as free antibiotics (azithromycin) for treatment of chlamydia in patients and their partners. Currently 18 Indian health care programs and one urban Indian center in the Portland area participate in the Stop Chlamydia! project.

Improving Screening and Treatment for STDs, HIV, and Hepatitis B

NCHSTP/DSTDP is pilot testing a system that combines surveillance, quality of care, and training to improve prevention for STDs. “ID WEB” is a system that pulls laboratory, diagnostic, treatment, and patient education information each month from IHS’s computerized records. “ID WEB” collects information on individual cases that have received screening, treatment, counseling, and been offered treatment for partners, analyzes the information, and makes it available on-line to providers. Providers can access facility-specific surveillance data, such as age and gender of patients; feedback on diagnosis, treatment, and counseling of patients; and web-based training on STD clinical care and prevention. Continuing education is available for providers who access the on-line training. Because specific performance feedback has been valuable in improving providers’ screening and treatment practices, this system shows promise for improving management of other diseases.

Diagnostic, Epidemiologic, and Outreach Services for TB Control

NCHSTP’s Division of Tuberculosis Elimination (DTBE) funding supports activities targeting AI/AN populations in cooperative agreements with states, cities and territories to promote tuberculosis (TB) elimination efforts. The cooperative agreements provide funds for 1) personnel, including TB control officers, medical consultants, epidemiologists, outreach workers to provide directly observed therapy, laboratory technicians and health educators; 2) materials, including supplies and equipment for TB testing; and 3) incentives for patients to continue and complete treatment. These resources are coordinated and shared with IHS and Tribal programs, to meet sporadic needs, in accordance with specific local agreements.

National Center for Infectious Diseases (NCID)

Hepatitis Prevention and Control

NCID’s Division of Viral Hepatitis (DVH) supports a cooperative agreement to the Alaska Native Tribal Health Consortium to fund a project titled “Evaluate the Long-Term Protection from Hepatitis A and B Vaccine among Multiple Cohorts of Alaska Natives Vaccinated and Study the Natural History of Chronic Hepatitis C among Alaska Natives.” The project assesses how well hepatitis A and B vaccines have protected Alaska Natives from these diseases, and examines the impact of hepatitis C on this population. The burden of hepatitis A and hepatitis B in both native and non-native people has been greatly reduced through vaccination. In fact, the effectiveness of hepatitis B vaccination in decreasing transmission of hepatitis B virus in rural Alaska is one of the great public health stories of the 20th century. DVH funding has also allowed a hepatitis A prevention brochure (focusing largely on vaccination) to be updated, printed, and distributed in paper and electronic forms to Indian sites nationwide. In addition, DVH, through an interagency agreement with IHS, funds community-based Viral Hepatitis Integration Projects (VHIPs) focuses on AIs/ANs. The goal of this program is to integrate testing for HIV and viral hepatitis into pre-existing programs for chemical dependency and sexually transmitted diseases. The programs also provide risk factor assessment, behavioral counseling, and referral for medical treatment. Currently funded organizations are: Na’Nizhoozhi Center, Inc., Gallup, NM; Seattle Indian Health Board, Seattle, WA; Phoenix Indian Medical Center, Phoenix, AZ; Fort Peck Tribal Health Department, Poplar, MT; and Tanana Chiefs Conference, Fairbanks, AK.

Pneumococcal Disease Prevention

NCID's Office of Minority and Women's Health (OMWH) provides funds in support of a 3-year research proposal titled, "Prevention of Pneumococcal disease in Alaska Native Elders." This project is conducted through collaboration with Alaska Native Tribal Health Consortium and Johns Hopkins University Center for American Indian and Alaska Native Health. The overall goal of this project is to demonstrate the effectiveness of a target effort to increase the 23-valent pneumococcal polysaccharide vaccine coverage in Alaska Native adults.

National Center for Injury Prevention and Control (NCIPC)

Reducing Motor Vehicle Injuries

NCIPC's Division of Unintentional Injury Prevention has developed a new program entitled, "Effective Strategies to Reduce Motor Vehicle Injuries Among American Indians/Alaska Natives". Approximately $186,000 is available to fund three awards to any federally recognized AI/AN tribe or tribal organization. Tribes and tribal organizations must have a minimum population size of 2,500 people, or serve 2,500 AI/AN people in order to be eligible to apply. The purpose of the program is to develop, implement, and evaluate community-based interventions with demonstrated effectiveness to reduce motor vehicle-related injuries among AI/AN. It is expected that the awards will begin on or about January 2004.

Building Capacity for Preventing Intimate Partner and Sexual Violence

In 2003, NCIPC's Division of Violence Prevention (DVP) funded the University of Arizona to evaluate the effectiveness of the Safe Dates: Adolescent Dating Violence Prevention Curriculum within the context of comprehensive youth development activities for AI/AN and Latino youth. Project staff works through University-affiliated Cooperative Extension offices in Gila, Coconino, and Navajo counties to implement dating violence prevention activities in collaboration with Reservation and non-Reservation schools and community settings.

National Immunization Program (NIP)

Student Opportunities, Training, and Vaccines for Children

In FY2003, NIP supported the American Indian Science and Engineering Society (AISES) Program by paying $10,701 for a student to work with a health communication specialist on the development of a training program for the Immunization CDCynergy Program. During the 2003 National Infant Immunization Week (NIIW) kickoff in Oklahoma, Dr. Orenstein presented to the immunization providers of the Choctaw Nation of Southeastern Oklahoma. As a follow up to the NIIW activities, two ISD staff presented on immunization practices to providers, nurses and nursing students at the Area Health Education Center (AHEC) spring meeting. NIP provided $8,000 in funding through an Interagency Agreement (02-FED17460-01) with the Indian Health Service to provide travel support for IHS Coordinators to attend the National Immunization Conference. NIP also directly funded a Public Health Advisor position assigned to the Indian Health Service in the amount of $80,593. The Public Health Advisor assisted in the planning, development and implementation of vaccine-preventable disease control programs for AI/AN, including the implementation of the Vaccines for Children (VFC) program among AI/AN children. In 2003, VFC purchased over $900 million in vaccines for children - birth through 18 years of age, who are eligible for the VFC entitlement, including AI/AN children. CDC estimates that 869,925 AI/AN children 0-18 years of age are VFC eligible. This represents 2.42% of the total U.S. population 0-18 years of age. In 2003, CDC granted over $72 million in categorical VFC operations funding to 61 state, city and

territorial immunization grantees. We do not have an estimate of the amount of these funds directed specifically for AI/AN children.

National Institute for Occupational Safety and Health (NIOSH)

National Occupational Research Agenda

In FY 2003, NIOSH spent approximately $1.5 million dollars in support of occupational safety and health research and services impacting Native (AI/AN and Native Hawaiian) populations. Most NIOSH programs are targeted to address the National Occupational Research Agenda (NORA), a list of 21 research priority areas to prevent injury and illnesses among all workers, especially workers in high-risk occupations and industries such as agriculture and construction. Some examples of our research and collaborative efforts with Native partners are highlighted in sections below.

Public Health Practice Program Office (PHPPO)

In FY 2003, PHPPO issued four (4) Program Announcements: Conference Support Grant Program; Initiative to Integrate Clinical Laboratories in Public Health Laboratory Testing; Research on the Impact of Law on Public Health; and Collaborating Centers for Public Health Law. Tribal governments and organizations were eligible to apply for all four, but no applications were received.

Office of the Director (OD)

Office of Minority Health (OMH)

Within OD, the Office of Minority Health (OMH) has maintained a cooperative agreement with the American Indian Higher Education Consortium (AIHEC) to "Enhance Research, Infrastructure, and Capacity Building for American Indian Tribal Colleges and Universities (TCUs)." The purpose of the program is to assist the AIHEC member TCUs in developing the commitment and capacity to promote education, student and professional development, evaluation and research, leadership and community partnerships that enhance the participation of American Indians and Alaska Natives (AI/ANs) in the public health professions; and to enhance the health status of AIANs in the United States.

Under this agreement, AIHEC has awarded $90,000 to Northwest Indian College to develop curricula and/or a project to address community-based public health concerns as a means of providing a culturally appropriate educational experience involving their students and faculty. Their program will encourage and inspire native students to assume greater roles in public health locally and nationally and will be shared with other TCUs to assist them in mimicking a like type program in their communities.

Office of Terrorism Preparedness and Emergency Response (OTPER)

In June, 2003 OD/OTPER added a position in the State and Local Readiness Program that is serving as the Tribal Liaison Officer. This individual's duties include having the responsibility for oversight, review and summarizing of Bioterrorism and Emergency Response tribal activities across the country related to CDC's BT Cooperative Agreement 99051. Although no funds are appropriated through CDC to directly fund tribal governments, CDC strongly encourages each state BT office to provide ongoing funds to their respective tribes. In a continuing process, a number of tribes have received contractual funds through their state BT program for implementation of Tribal BT initiatives. In addition, new State Action Plans are being developed by OTPER Project Officers that will include a Tribal component specifically addressing certain critical capacities of the Cooperative Agreement 99051;i.e., Preparedness Planning and Readiness Assessment, Surveillance and Epidemiology Enhancement, Biological Laboratory Enhancement, Chemical Laboratory Enhancement, Support for Communications and Information Technology (Public Health Information Network, Health Alert Network), Enhancement of Risk Communication and Health Information Dissemination, Enhancement of Education and Training.

2. INTERGOVERNMENTAL RELATIONS AND RELATED ISSUES

Encouraging collaboration between state and tribal governments remains a high priority for CDC. In 2003, CDC staff again helped to conduct an AI/AN public health session at the annual meeting of the Council of State and Territorial Epidemiologists (CSTE). In attendance were representatives from each of the Tribal Epidemiology Centers. CDC and CSTE are also working directly with tribal health facilities to assess surveillance and reporting practices. Enhanced federal cooperation on behalf of tribes is also a high priority for CDC. In this regard, CDC/ATSDR has partnered with IHS to form the CDC/ATSDR/IHS Senior Policy Workgroup, which meets twice a year to improve inter-agency coordination. This workgroup serves to focus and strengthen collaborative activities between CDC/ ATSDR and IHS by articulating shared visions, priority issues, and possible collaborative approaches for improving public health in Indian country. Within a number of CDC categorical programs, tribal – state – federal cooperation is often enhanced by CDC staff and projects, as described in the examples that follow:

NCHSTP, Office of the Director

Public Health Surveillance Among AI/AN People

In FY 2003, NCHSTP/OD Office of Health Disparities staff and partners (RTI International and Kauffman and Associates) met with members of the Health Subcommittee of the National Congress of American Indians as part of the stakeholder engagement phase of a project to assess how current HIV, STD, TB and viral hepatitis surveillance systems serve AI/AN people. In the next phase of the project, focus groups were conducted at a joint meeting of the California Rural Indian Health Board and the Northwest Portland Area Indian Health Board and at a meeting of the Aberdeen Area Tribal Chairman's Health Board. In addition, key informant interviews were conducted with officials in 7 tribal health facilities. The purpose of these focus groups and key informant interviews was to explore the extent to which tribal health agencies participate in surveillance; describe the availability of tribe-specific health data, data sources, and tribal authority to access them; and develop an understanding of existing surveillance processes as they related to the AI/AN population, as well as surveillance successes and challenges.

NCHSTP, Division of STD Prevention

Addressing Increases in Syphilis Cases in the Four Corners Area

Starting in January 2000, the number of cases of syphilis identified in the Navajo Nation began to rise, and in 2001, there were three congenital syphilis cases. In response, the Indian Health Service and the Navajo Nation requested assistance from NCHSTP/DSTDP, which sent an STD Syphilis Rapid Response Team to help understand the increases. Risk factor analysis showed a correlation between syphilis transmission and alcohol abuse. CDC, the Navajo Nation, the New Mexico Department of Health, Arizona Department of Health, and the IHS National Epidemiology Program worked together to conduct targeted screening efforts to identify and treat patients infected with syphilis. Although the number of newly identified cases stabilized during 2002, preliminary 2003 data showed a second resurgence. NCHSTP/DSTDP deployed a second Rapid Response team to conduct more in-depth analysis of causes of transmission. The Navajo Nation Division of Health, the Indian Health Service, and the state health departments of Arizona, New Mexico, Colorado, and Utah met to develop a response plan that outlines ways to build capacity for all STD issues. This meeting also provided an opportunity to develop memoranda of agreement between the states and Navajo Nation, and clarify roles of the groups that are working together. In addition, NCHSTP is increasing support for development of local capacity and infrastructure to prevent and control STDs including HIV.

NCID, Arctic Investigations Program (AIP)

AIP is located on the Alaska Native Health Campus in Anchorage. The mission of AIP is prevention of infectious diseases among people of the Arctic and sub-arctic with a special emphasis on diseases of high incidence and concern among Alaska Native (AN) populations. Employees from CDC, the Alaska Native Tribal Health Consortium, South-central Foundation, Indian Health Services, and the University of Alaska staff the CDC laboratory and office in Anchorage. Current problems addressed by AIP include infections caused by drug-resistant bacteria, vaccine-preventable diseases, chronic diseases caused by infections, and bioterrorism preparedness and response. AIP laboratory is part of the Laboratory Response network, a multi-level system connecting local and state public health, veterinary, food, and water laboratories with advanced capacity laboratories. This is one of two such laboratories in Alaska. AIP staff members also assumed a major role in the Severe Acute Respiratory Syndrome (SARS) outbreak. AIP staff members were deployed locally and in Ottawa to participate in the public health response. AIP staff met all incoming passenger aircrafts from SARS-affected areas to discuss health alerts notices, to provide health screening and to provide additional information as needed. AIP staff members also participated in the Northwest SARS working group, which provided a forum for quick exchange of information among public health professionals in Alaska, the Yukon, British Columbia, and Washington, as well as officials from CDC in Atlanta, Health Canada, and the cruise line industry.

NCID, Division of Viral Hepatitis (DVH)

Since 1999, DVH has supported a full-time Medical Officer at the IHS National Epidemiology Program, in Albuquerque, NM. This epidemiologist coordinates joint CDC/IHS activity around viral hepatitis epidemiology, research, prevention, and policy. The epidemiologist also serves as Project Officer for five CDC-funded Viral Hepatitis Integration Projects (VHIPs) in Indian populations. Since 2003, DVH has also supported a full-time Research Officer at the IHS National Epidemiology Program (NEP). This epidemiologist serves as coordinator of hepatitis C prevention activities for the IHS and as Operational Supervisor for the five Indian VHIPs. The two positions assigned to the IHS NEP by DVH cover AI/AN nationwide, whether the populations are medically served by IHS, a Tribal program, or an Urban Indian Health Center. This arrangement allows CDC to maintain collaborative relationships with all types of health facilities serving AI/AN, and serves to promote close working relationships with state health departments. The following are highlights of CDC program activities that enhance tribal – state – federal cooperation and partnerships:

Epidemiology Program Office (EPO)

New Mexico Department of Health Assessment Project

In September 2002, the New Mexico Department of Health (NM DoH) received $165,000/first year –five year cooperative agreement to enhance the quality and scope of community health assessment practices through more systematic evaluation, coordination, and training from the Division of Public Health Surveillance and Informatics, EPO. One of the main projects is providing direct epidemiology support to the 22 tribes within the state. Through this support, it is hoped to improve the knowledge of the community health status among tribes; improve the quality and scope of assessments conducted; and increase the number of tribes with community-level evidence to improve public health programs and policies. With this support, the NM DoH has established a tribal epidemiologist position. This new tribal epidemiologist has been instrumental in the development of a methodology to create inter-censal population estimates by tribe. In addition, planning has begun to add a tribal affiliation field to the reportable infectious disease database was initiated to provide access to tribal-specific infectious disease data for use in assessment, planning, and prevention activities. A tool was developed to evaluate current tribal assessment capacity and completed with five tribes. Finally, the development of an American Indian data report for the state of New Mexico was initiated. Bi-monthly meetings of the Native American Data Advisory Work Group are coordinated as a means for tribes, universities, and state health department staff to share past/present projects and needs relating to use of health information. As a result, two collaborative projects were initiated between the NMDOH and individual tribes: 1) Analysis of Jemez Pueblo asthma survey data, and 2) Analysis of Navajo Nation vital records data.

Public Health Practice Program Office (PHPPO)

National Public Health Performance Standards Program (NPHPSP)

Working with tribal and IHS partners, public health professionals from PHPPO, CDC's Epidemiology Program Office (EPO), NCCDPHP/ DCPC, and OMH/OD are working with numerous tribal and state/local health departments to implement NPHPSP assessment activities in several tribal and IHS settings. In the context of evaluating how well the local or regional public health "system" is providing essential public health services to AI/AN communities, public health professionals from multiple jurisdictions and organizations are brought together – often for the first time. In July, 2003, two Tucson Area Tribal Nations conducted an assessment using the National Public Health Performance Standards Program (NPHPSP) Local Public Health System Performance Assessment. A CDC Public Health Prevention Specialist (EPO) and a CDC medical epidemiologist (NCCDPHP), both field-assigned to the IHS National Epidemiology Program in Albuquerque, coordinated the process over a period of several months with the IHS Area Offices, Tohono O'Odham and Pascua Yaqui Tribal Nations, the Inter Tribal Council of Arizona, University of New Mexico and Atlanta-based PHPPO staff. Also, PHPPO, in a partnership with National Association of County and City Health Officials (NACCHO), provided four (4) regional trainings about the planning processes described in the National Public Health Performance Standards Program and the Mobilizing for Action through Planning and Partnerships (MAPP) tool. Tribal Agency representatives and IHS staff participated in some of these trainings.

Office of the Director (OD), Office of Minority Health (OMH)

Within the CDC Office of the Director (OD), OMH has responsibility for coordinating the agency's programs and policies that benefit AI/AN communities. To lead these efforts, two full-time professional staff positions have been established within OMH/OD to help plan and coordinate CDC programs for AI/AN communities: the Senior Tribal Liaison for Policy and Evaluation and the Senior Tribal Liaison for Science and Public Health. Located in Atlanta, GA and Albuquerque, NM, respectively, these senior staff members report directly to the Associate Director for Minority Health and serve as official CDC points-of-contact for issues relating to AI/AN health. As liaisons they work to facilitate and strengthen relationships between tribal governments and organizations, federal agencies, and state/local health departments. In addition, they work closely with CDC's Centers and Offices (CIOs) that have programs and activities involving AI/AN communities, and with ATSDR's Office of Tribal Affairs. A critical component of their duties is to network with CDC CIOs to help integrate categorical projects and personnel by connecting CDC expertise and support with tribal communities.

Office of the Director (OD), Office of Terrorism Preparedness and Emergency Response (OTPER)

OTPER recognizes the critical role of AI/AN communities in the nation's effort to be better prepared for terrorism and other public health emergencies. CDC/OTPER is committed to working with AI/AN tribes, villages and corporations on a government-to-government basis and upholding the federal trust responsibility. OTPER is working with other CDC centers and offices, IHS, the Health Resources Services Administration (HRSA), the Agency for Toxic Substances and Disease Registry (ATSDR), the Environmental Protection Agency (EPA), the National Indian Health Board, Area Indian Health Boards, Inter-Tribal Councils, Tribal Epidemiology Centers, and various tribal health entities in strengthening terrorism preparedness and emergency response capabilities in AI/AN governments, communities, and organizations.

In FY 03 OTPER staff participated in 5 DHHS Regional Tribal Consultation Sessions; Las Vegas, Nevada (Region 9), Albuquerque,

New Mexico (Region 6), Nashville, Tennessee, (Region 4), Denver, Colorado (Region 8), Anchorage, Alaska, (Region 10). Staff formally introduced and discussed the future of the new office/program. In addition, staff participated in the listening/consultation sessions between the tribes and Federal OPDIV's.

In addition, OTPER staff has been involved in discussions with IHS, ATSDR, and NIHB in the support and creation of a National Native American Task Force, a standing committee that would address Bioterrorism and Emergency Preparedness on a National level impacting programs out in Indian Country.

3. SERVICES AND SERVICE PROVISIONS

Although this section is not directly applicable to CDC (CDC does not provide direct clinical services), several CDC programs strive to strengthen linkages between clinical and preventive health services. Details of such programs are provided elsewhere in this document, but prominent examples include the Breast and Cervical Cancer Early Detection Program, the WISEWOMAN Program, the Comprehensive Cancer Control Program, the Viral Hepatitis Integration Projects, the ID WEB project, the Stop Chlamydia! Project, the Tobacco Support Centers program, HIV counseling and testing services, and immunization programs.

4. CARE PROVIDERS

Not applicable to CDC; however, a number of CDC's Commissioned Officers are medical professionals who choose to complete their required (minimum of 2 weeks annually) clinical activities at IHS or tribal facilities throughout the country (e.g., Alaska, Arizona, New Mexico, South Dakota).

5. FACILITIES, EQUIPMENT, AND SUPPLIES

Not Applicable to CDC.

6. INFRASTRUCTURE

CDC is not directly involved in water/sewer maintenance/repair, but its mission does include the monitoring and prevention of waterborne diseases, fluoridation projects, and certain occupational safety and health efforts that may fit within this category. Examples include:

NCDPHP, Division of Oral Health

In FY 2003, CDC provided funds and technical assistance to IHS to support a water fluoridation specialist. The specialist provides training and technical assistance to tribes in the Phoenix and Albuquerque Areas of IHS to improve the quantity, quality and consistency of water fluoridation. These efforts improve the effectiveness of water fluoridation in reducing tooth decay in tribal communities.

NIOSH

NIOSH's mandate also includes training occupational safety and health professionals. The goal is to have competent professionals trained in such areas as industrial hygiene, to address issues dealing with water systems. Hopefully, our Training Project Grants such as the University of Oklahoma Health Science Center grant will assist in this effort (FY 2003 funding $61,578). NIOSH has supported a workforce development award with the University of Oklahoma since 1998. This grant provides two master's degree programs in the College of Public Health: Industrial Hygiene or Industrial Hygiene/ Environmental Management. The university programs are a resource serving the AI/AN community in the region. The purpose of the NIOSH training grant is to recruit AI/AN and other qualified trainees into the field of industrial hygiene, provide support for an industrial hygiene management program and strengthen current educational activities. Presently, two AI/AN students are enrolled in the program. In addition, three students have graduated from the program since 1998.

NIOSH also conducts surveillance activities, shares information with AI/AN communities, and implements intervention projects to reduce and prevent injuries among AI/AN workers and their families. For example, NIOSH has conducted health hazard evaluations at two Indian reservations: an evaluation of an aquaculture facility at the Chippewa Reservation requested by the St. Croix Chippewa Indian Tribe; and an evaluation of exposure to contaminants during coin and paper counting at the Lac Vieux Desert Resort and Casino in Watersmeet, Michigan requested by the Band of Lake Superior Chippewa Indians. Currently, NIOSH supports workshops for community members, health care providers, and as many as 15 western tribes on the recognition, diagnosis and management of pesticide-related illnesses and injuries. Details of the specific services provided are described in our Navajo Nation project and our Western Center for Agricultural Safety and Health at the University of California, Davis campus.

7. DATA AND RESEARCH

In collaboration with its numerous partners (tribal, state, federal, academic, etc.), CDC compiles and analyzes health data and conducts public health research about health issues of importance to AI/AN people. The following are highlights of data and research activities conducted during FY 2003:

NCCDPHP, Division of Adult and Community Health (DACH)

Behavioral Risk Factor Surveillance

The Behavioral Surveillance Branch (BSB) in the Division of Adult and Community Health conducts, in collaboration with state health departments, the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a telephone survey of adults focusing on health behaviors related to chronic disease. BSB analyzes and publishes reports based on data from AI/AN respondents in collaboration with the IHS. It provides data and technical assistance to Tribal Epidemiology Centers and the CDC Prevention Research Centers. States also analyze data from AI/AN respondents.

NCCDPHP, Division of Adolescent and School Health (DASH)

Youth Risk Behavior Surveillance System

CDC developed the Youth Risk Behavior Surveillance System (YRBSS) to monitor health risk behaviors associated with the leading causes of morbidity and mortality among youth and adults. National YRBSS data representing AI/AN youth are not available because the number of students completing the survey from this racial group was too small for meaningful analysis. Consequently, the Bureau of Indian Affairs conducted an YRBSS survey among high school students attending BIA-funded schools in 1994, 1997, and 2001 and among middle school students in 1997 and 2000. In addition, in 1997 and 2000, with assistance from the Indian Health Service, the Navajo Nation conducted a survey among high school students attending public schools on the Navajo Nation reservation and students attending border-town schools with a Navajo enrollment of at least 50 percent. CDC has provided technical assistance in survey administration and in using YRBSS data.

NCCDPHP, Division of Cancer Prevention and Control (DCPC)

Cancer Registries

Previously documented racial misclassification of AI/AN people in cancer registry data affects cancer statistics and hampers program planning for cancer prevention and control efforts for these populations. To address these problems, DCPC developed protocols for state cancer registries to conduct case ascertainment for AI/AN using IHS administrative encounter data. IHS and CDC conducted a 1-year data linkage project to help registries more accurately describe the burden of cancer among AI/AN. Data from 25 state registries in the NPCR will be linked with data from the IHS patient registration records to improve the classification of AI/AN race in the registries. Preliminary results are anticipated in late 2003.

Economic Barriers to Preventive Cancer Screening

This study will use data from the Behavioral Risk Factor Surveillance System to examine how income, insurance status, and perceptions of cost as a barrier to medical care affect participation in screening for breast and cervical cancers. Researchers will also look at the role of NBCCEDP in changing the behavior of uninsured women toward breast and cervical cancer screening services.

NCCDPHP, Division of Reproductive Health (DRH)

Pregnancy Assessment and Monitoring System (PRAMS)

PRAMS is an ongoing, population-based surveillance system designed to identify and monitor selected maternal behaviors and experiences that occur before, during, and after pregnancy among a sample of mothers who have recently delivered a live birth. PRAMS collects data on a wide range of maternal and child health (MCH) indicators such as intendedness of pregnancy, access to and use of prenatal and infant care, payment source for prenatal care, alcohol use, smoking, violence during pregnancy, multivitamin consumption, infant sleeping position, and economic status of the mother. Currently, PRAMS is operating in 31 states and New York City, all states collect data from AI/AN residents and some states oversample AI/AN populations, including Alaska, Nebraska, and Washington.

Study of Sudden Infant Death Syndrome (SIDS)

Among the IHS Areas, the highest infant mortality rate has consistently been found in the Aberdeen Area (20 per 1,000), with a SIDS rate 4-5 times higher than the national average. The goal of this study is to reduce infant mortality in the Aberdeen Area by improving knowledge about the causes of deaths among infants. Enrollment of cases was completed in December 1996, and recruitment of controls, all data collection, entry, and editing, and preliminary analysis were completed late in 1997. High rates of SIDS were found among AI/AN in the IHS Aberdeen Area. The results of the study were presented to the tribes. A report of study results was prepared for the Aberdeen Area Tribal Chairmen's Health Board and published for dissemination to the community and health staff in June 1998. Analyses were presented at the IHS Research Conference and American Public Health Association Annual Conference. The study was published in the Journal of the American Medical Association in December of 2002.

In addition, collaborative work on serotonergic brainstem abnormalities in Northern Plains Indians with the Sudden Infant Death Syndrome has been accepted for publication in the Journal of Neuropathology and Experimental Neurology.

Ponca Tribe of Oklahoma Survey

DRH provided assistance to the Ponca Tribe (Ponca City, OK) for the design and implementation of a health assessment survey of tribal members living in the Ponca City area. Fieldwork was completed in November 2002. Preliminary results were presented at a series of tribal dissemination meetings in July 2003. An electronic presentation was prepared by CDC and given to tribal officials and regional Indian Health Service staff for their use.

Tohono O'odam Reservation (AZ) Health Status Assessment

DRH also worked with the Tohono O'odham tribe, IHS, and the Inter-tribal Council of Arizona to develop and implement strategies for assessing health status and the prevalence of behavioral risk factors of tribal members living on the reservation. The first phase of the project was to conduct a health assessment survey of tribal members living in the four western districts of the reservation. This was successfully concluded and tribal health officials presented the data in early 2002. Phase II of the project, a survey using the same questionnaire in the remaining districts of the reservation, has been completed. Survey results have been used to plan prevention and treatments services to address the tribe's health priorities [diabetes, alcohol use, injuries and violence]. Data have also been used to compare the health indicators between tribal members living in Mexico and the U.S. Finally, these data have played a role in the planning of a new clinic to serve residents on the reservation's West End. Results were reported at several meetings (including national meetings) in November 2002.

NCCDPHP, Office on Smoking and Health (OSH)

Adult Tobacco Survey

OSH funded six Tribal Support Centers (TSCs) to conduct a pilot study of the Adult Tobacco Survey (ATS). This survey is known as the Tribal ATS. Part of the pilot study includes modifying the existing ATS to be culturally appropriate for AI/AN. The goal is to assist tribes in identify community specific tobacco behaviors and develop culturally appropriate and effective tobacco control measures. The TSCs expect to implement the Tribal ATS in Fall 2003. The Tribal ATS will be accompanied by training on survey implementation with ongoing technical assistance to the tribes on methodology and sampling. To conduct this study, CDC is collaborating with various tribal governments and the National Center for Health Statistics.

National Center for Health Statistics (NCHS)

The Questionnaire Development and Research Laboratory at the National Center for Health Statistics is conducting Cognitive Testing of Survey questions that cover various measures important to public health research and health disparities. The measures include health status, health conditions, health behaviors, and socioeconomic status. The purpose is to use the testing to inform changes in the way questions are written and asked in personal interview surveys, e.g., the National Health Interview Survey, in order to reduce measurement bias. This improves public health surveillance and allows research and programs to be targeted more effectively to needy communities. This effort includes participants from tribes in California, Michigan, Oklahoma, and South Dakota.

Staff members conducted an important study that demonstrated that disability is a major problem for adults in the AI/AN population, including those who live in metropolitan areas. Regardless of the measure of disability used, comparisons between AI/AN and other racial/ethnic groups show that AI/AN have higher proportions of functional limitations, sensory limitation, ADL or IADL difficulties or limitations in major activities.). Almost one-third (32 percent) of the total AI/AN adult population report some type of limitation. The prevalence of physical limitations within the AI/AN population is not skewed to the elderly population alone, but is substantially greater than for other racial/ethnic groups among persons aged 18 to 44.

NCHSTP, Office of the Director

Map to LOINC Project

Standardization of laboratory test names is an essential step for health information to be aggregated across clinical facilities or communicated with other information systems (e.g., for public health surveillance and agency performance evaluation purposes). Through its interagency agreement with IHS, the Office of the Director, NCHSTP, provided ongoing technical assistance in FY 2003 to map clinical laboratory tests to standardized Logical Observation Identifier Names and Codes (LOINC). The purpose of this project is to enhance data exchange capability.

NCHSTP, Division of HIV/AIDS Prevention (DHAP)

Evaluation of Racial Misidentification in HIV/AIDS Surveillance Databases

In FY 2003, NCHSTP/OD and DHAP continued analysis of data from projects to evaluate racial misidentification of AI/AN persons in HIV/AIDS surveillance databases in 5 states and 1 county (Alaska, Arizona, California, Oklahoma, Washington, and Los Angeles). These areas represent states and the urban area with the highest concentration of AI/AN AIDS cases. The project will also investigate factors associated with racial misidentification of HIV/AIDS cases among AI/AN and make recommendations to prevent future undercounting of AI/AN HIV/AIDS cases.

HIV Testing Surveys

Beginning in fiscal year 2001, NCHSTP/DHAP funded the Northwest Portland Area Indian Health Board to conduct the HIV Testing Survey, which involves anonymous interviews with AI/AN persons at high risk of acquiring HIV infection. The purpose of the survey is to assess the reasons and barriers that influence persons to seek or avoid HIV testing, knowledge of state policies for HIV surveillance, HIV testing patterns, behavioral risk factors, and exposure to prevention efforts. These data are used to evaluate the representativeness of HIV surveillance data and for local HIV prevention and community planning. An initial survey targeted AI/AN residents in an urban area. In FY 2003, the survey was conducted on two Indian reservations in Oregon and Washington.

NCHSTP, Division of STD Prevention (DSTDP)

Addressing Racial Misidentification in STD Surveillance Data

To measure racial misidentification occurring in one State, NCHSTP/DSTDP supported a study of five years' worth of data from two major health information databases in Oregon. Researchers compared almost 40,000 records from the State's STD files with about 147,000 records from the Northwest Tribal Registry. Comparison of the two databases showed significant misclassification of AI/AN records. Results are being shared with the Northwest tribal health care programs so that they are aware of the burden of disease in their communities. In addition, findings are being shared with managers of the State program and the tribal communities so that they can take steps to improve patient classification.

NCID, Arctic Investigations Program (AIP)

Increased rates of drug resistance have been reported by AN hospitals and detected through ongoing CDC surveillance. The germs of greatest concern and the diseases that they cause are: *Streptococcus pneumoniae* (also known as the pneumococcus), the leading cause of ear infections, pneumonia, and bacterial meningitis, and methicillin-resistant *Staphylococcus aureus (MRSA)*. Since January 2001, AIP surveillance has documented that rates of pneumococcal bloodstream infections and meningitis among AN children aged less than 2 years have declined by 90%. This has been accompanied by declines in drug-resistant infections. MRSA infections have been troublesome in hospitals for decades. Since 2000, the number of MRSA infection apparently acquired in the community has increased dramatically in rural Alaska Native villages. Investigations conducted collaboratively by AIP and the Yukon-Kuskokwim health Corporation (YKHC, a Native health corporation in southwestern Alaska) identified previous uses of antibiotics and use of crowded traditional saunas. AIP and UKHC staff members have developed clinical management guidelines for skin and soft tissue infections to decrease unnecessary use of antibiotics. Future measures should include methods to decrease transmission within saunas and households.

Helicobacter pylori causes ulcers and may contribute to development of stomach cancer. Rates of stomach cancer are three-fold higher among Alaska Natives compared with rates for the entire U.S. population. *Helicobacter* may also cause chronic bleeding from the stomach and contribute to the high rates of anemia in Alaska Natives. Nearly one-quarter of isolates from Alaska Natives which are tested at CDC are resistant to two of the antibiotics commonly used to treat this infection (clarithromycin and metronidazole). Data from Alaska Native Medical Center and CDC show that those people who have taken antibiotics, even up to 5 years before diagnosis of *Helicobacter* infection, are more likely to be infected with drug-resistant strains. This is the first evidence that antibiotic use may influence outcome of infections diagnosed years later and the findings for studies of *Helicobacter* in Alaska are being incorporated into treatment guidelines for clinicians at tribally operated health centers.

The effectiveness of hepatitis B vaccination in decreasing transmission of hepatitis B virus in rural Alaska is one of the great public health stories of the 20th century. Prior to availability of vaccine in the early 1980s, nearly 10 percent of the Native population in some areas had chronic infection with hepatitis B virus. These persons are at increased risk for cirrhosis and cancer of the liver, and are also capable of transmitting infection to others. Beginning in 1983, a program to eliminate new hepatitis B infections was launched—53,000 Alaska Natives were tested and those who were not infected or were not immune were vaccinated against hepatitis B. Since that time, Alaska Native infants have been routinely vaccinated. As a result, new infections with hepatitis B virus were virtually eliminated during the 1990s. However, the duration of full protection provided by the vaccine and the possible need for a booster dose of vaccine to maintain protection are unknown. Therefore, AIP, CDC/NCID's Division of Viral Hepatitis, the Alaska Native Tribal Health Consortium, and regional Native health corporation have undertaken a 20-year follow-up of persons vaccinated through this program to determine whether booster doses of vaccine are needed to protect the public health gains that have been achieved.

NCID, Division of Vector-Borne Infectious Diseases (DVBID)

In addition to training and epidemiologic responses, DVBID has an active research program involving collaborations between IHS, NASA, USGS and state health departments in the region. This research is designed to identify conditions associated with increased human plague risk on AI/AN lands and surrounding areas in the Southwest. Among the research completed to date is a mathematical modeling study that clearly indicates a close link between climatic variations and the frequency of human plague in the Four Corners region. Additional GIS-remote sensing studies on AI/AN lands and other sites in the Southwest have shown that exposure sites for human plague cases are closely correlated with the presence of certain habitat types. Our collaborative studies are significant because they provide data that can be used to design improved plague surveillance programs and make more efficient use of limited prevention resources.

NIOSH

Western Center for Agricultural Safety and Health

California Davis campus has been conducting an inter-tribal project since FY 2002. The Center investigators collaborated with the Inter-Tribal Council of Arizona to conduct three 8-hour workshops on recognizing and managing pesticide illnesses and injuries. Workshops were held in Yuma and Phoenix, AZ. They were designed for community members and health care providers from 15 western tribes. These workshops provided key clinical personnel and others with information, resources, and training skills to assist them in training others in the recognition, diagnosis and management of pesticide-related illnesses and injuries. The workshops also provided participants with information about the legal requirements for reporting suspected and actual pesticide-related injuries. Seventy-eight community members participated in the workshops.

Health Survey of Minority and Female Farm Operators

Since 1997, the U.S. Department of Agriculture's National Agricultural Statistics Service (USDA/NASS) has conducted the Census of Agriculture. This Congressionally mandated survey includes self-reported racial and ethnic demographics of farm operators. The existence of this database made it possible for CDC/NIOSH and USDA to collaborate on a population-based occupational health survey of minority and female farm operators. The study population ranged from 18–95 years of age with a median of 54 years. They had a median of 13 years of education, and 30 years in farm work. Statistically significant differences in prevalence of health conditions between AI/AN farm operators and white farm operators include:

- AI/AN farm operators had a higher prevalence of (a) respiratory problems (male 15.5%, female 17.1%, compared to white male 13.7%, and white female operators 14.7%); (b) hypertension (male 33.0%, female 33.8% compared to white male 27.6%, and white female operators 29.3%); and (c) diabetes (male 12.2%, female 9.7% compared to white male 7.5%, and white female operators 7.2%).

- AI/AN men also had a higher prevalence of musculoskeletal problems (60.4% compared to white male operators, 56.3%)

These results were presented at the 2002 American Public Health Association (APHA) Annual Meeting in Philadelphia. Two abstracts were accepted for presentation at the APHA 2003 Annual Meeting: "Mental health symptoms in a population-based survey of minority farm operators" and "Occupational hearing loss in a population based survey of US minority farm operators." Analyses of the survey are being prepared for publication in FY04.

Markers of Brain Tissue Injury and Alzheimer's Disease and Parkinson's Disease

This occupational exposure research is being conducted with NIH, VA, the Hawaii Department of Health, and the Pacific Health Research Institute. In an autopsy sub-study of a cohort of Japanese-American men (which has both occupational and environmental data), the research aimed to use biomarkers of neurotoxin damage to provide clues into the potential role that certain chemicals may play in contributing to these diseases. This collaboration will provide valuable risk assessment information and early disease intervention measures for Native Hawaiians and the general population. In 2002, a publication was released that documented indicators of brain damage in patients with Alzheimer’s disease and Parkinson’s disease.

Southwest Center for Agricultural Safety and Health

NIOSH is currently funding an intervention effectiveness project at the Southwest Center for Agricultural Safety and Health, through the University of New Mexico Health Sciences Center that addresses the needs of the Navajo Nation. The goal of this intervention "Navajo Nation Evaluation" is to engage community stakeholders in the planning, implementation, and assessment of a culturally appropriate model program to reduce and prevent agricultural-related injuries in the Navajo Nation. The intervention effectiveness evaluation addresses three specific aims: (1) Convene a stakeholder group to understand the contributing factors to agricultural-related injuries on the Navajo Nation and describe the theoretical foundations of a science-based intervention to influence those factors. (2) Support the development and implementation of a science-based, culturally-appropriate model program to reduce and prevent injury among Navajo agricultural workers and their families. (3) Evaluate the implementation and the outcomes of this model program to reduce and prevent injury among Navajo agricultural workers and their families. The major activities of the project have been: 1) strengthening collaborative linkages between community stakeholders of the Navajo Nation and evaluators from the University of New Mexico; 2) finalizing and pilot testing of the baseline survey instrument; 3) training of surveyors to implement the baseline survey; 4) developing the survey sampling strategy; and 5) overseeing implementation of 220 baseline surveys in December of 2002. The work to date is providing needed insight into the practicalities of carrying out survey research on agricultural injury, as well as other topics in largely rural and ethnically diverse settings. The results of this research will prove pivotal to the design of culturally-relevant public health programs aimed at reducing the adverse impacts of agricultural injury. The project is funded through FY05.

Epidemiology Program Office (EPO)

Morbidity and Mortality Weekly Report (MMWR)

The *MMWR* is published weekly by the Office of Scientific and Health Communications, Epidemiology Program Office. In addition to the weekly publication, serial publications (*MMWR Recommendations and Reports and Surveillance Summaries*), occur at irregular intervals - a frequency of about two a month. The articles summarized below appeared in the August 1, 2003, issue that was dedicated to health disparities experienced by American Indians/Alaska Natives. The citation for all these articles is as follows: Centers for Disease Control and Prevention. [Article title].MMWR 2003; 52: [inclusive page numbers]. Copies can be found at http://www.cdc.gov/mmwr. CDC staff from several CDC Centers and Offices collaborated with tribal public health professionals, IHS colleagues, and state health departments to produce these reports.

- *Surveillance for Health Behaviors of American Indians and Alaska Natives: Findings from the Behavioral Risk Factor Surveillance System, 1997-2000*

  In the United States, disparities in risks for chronic diseases (e. g., diabetes, cardiovascular disease, and cancer) and human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) are evident among AI/AN and other groups. This report summarizes findings from the 1997-2000 Behavioral Risk Factor Surveillance System for health-status indicators, health-risk behaviors, and HIV testing and perceived risk for HIV infection among AI/ANs, compared with other racial/ethnic groups in five regions of the United States.

- *Health Disparities Experienced by American Indians and Alaska Natives*

AI/AN are a heterogeneous population with approximately 560 federally recognized tribes residing in the rural and urban areas of 35 states. Of all racial/ethnic populations, AI/ANs have the highest poverty rates (26%)—a rate that is twice the national rate. This issue of MMWR describes disparities in health for certain preventable conditions.

- *Injury Mortality Among American Indian and Alaska Native Children and Youth, U.S., 1989-1998*

  This CDC study found that injuries and violence account for 75 percent of all deaths among children and youth from one to 19 years old in this population. The risk of injury-related death is about twice that of all children and youth in the country and the risk for AI/AN varies from one region of the country to another. CDC researchers found that more than 3,300 AI/AN children and youth living on or near reservations died as a result of injuries or violence between 1989 and 1998. While injury death rates declined for motor vehicle crashes (18 percent), drowning (34 percent), fire (49 percent), and pedestrian incidents (56 percent); rates increased for firearm-related deaths (13 percent) and homicide (20 percent). Because each AI/AN community is unique, CDC researchers recommend that addressing local practices and cultures can help future prevention measures to narrow the injury disparity gap with other children in America.

- *Diabetes Prevalence Among American Indians and Alaska Natives and the Overall Population - U.S., 1994-2002*

  Diabetes affects AI/AN disproportionately compared with other racial/ethnic populations and has been increasing in prevalence in AI/AN populations during the past 16 years. To examine trends in diabetes prevalence among AI/ANs and the overall U. S. population and to describe disparities among these two populations, CDC analyzed data from the Indian Health Service and the Behavioral Risk Factor Surveillance System. This report summarizes the results of that analysis.

- *Cancer Mortality Among American Indians and Alaska Natives, U.S., 1994-1998*

  In the United States, public health interventions to control infectious diseases, lower infant and maternal mortality, and improve basic sanitation have led to a substantial increase in life expectancy for American Indians and Alaska Natives. To understand cancer mortality among AI/ANs subsequent to 1989-1993, the Indian Health Service and CDC analyzed death certificate data provided by CDC's National Health Statistics for deaths among AI/ANs in five U. S. geographic regions during 1994–1998. This report summarizes the results of that analysis.

- *Bronchiolitis-Associated Outpatient Visits and Hospitalizations Among American Indians and Alaska Native Children, U.S., 1990-2000*

  Rates of bronchiolitis-associated hospitalization for AI/AN children are approximately twice that for the general population of U. S. children. This report describes the first estimate of rates of outpatient bronchiolitis-associated visits and updates rates of bronchiolitis-associated hospitalizations in these populations.

- *Vaccination Coverage Levels Among Alaska Native Children Aged 19-35 months, National Immunization Survey, U.S., 2000-2001*

This report indicates that Alaska Native (AN) children aged 19–35 months have a high level of vaccination coverage that exceeds the national goal for 2010 of 90% for all vaccines except Varicella and the fourth dose of DTP. This achievement, despite the presence of barriers to vaccination, demonstrates the commitment of AN communities, tribal corporations, and state public health departments to address health concerns and exemplifies the effectiveness of using multiple strategies (e.g., reducing financial and access barriers, making vaccination a priority, using collaborative efforts, tracking and recall, assessment, and registries).

Changes in Health Disparities in New Mexico

Rebecca Drewette-Card, a Public Health Prevention Service Fellow in the Epidemiology Program Office (Class 2000) worked with the New Mexico Department of Health to address health disparities. Ms. Drewette-Card utilized data from the New Mexico Office of Vital Records and Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), National Electronic Telecommunication System for Surveillance (NETSS), Pregnancy Risk Assessment Monitoring System, (PRAMS) and Youth Risk and Resiliency Survey (YRRS) to analyze disparities by race/ethnicity and sex around 25 key health indicators. Additionally, some indicators were analyzed by income and education level. A disparity change score was used to examine disparities over time. Results identified significant differences in rates between White Non-Hispanics, White Hispanics and AI/AN. AI/AN have the poorest health status and White Non-Hispanics have the best health status of New Mexico racial/ethnic groups. This surveillance research allowed the Health Department to identify health disparities affecting AI/AN in NM. In NM AI/AN are experiencing the worst rates of health disparities. Currently, the NM DOH is working with the State Secretary of Health to prioritize disparities and develop systematic mechanism for targeting resources to eliminate disparities.

Racial Misclassification Project in New Mexico

Chad Smelser, an Epidemic Intelligence Officer with the Epidemiology Program Office (Class 2002) worked on an AI/AN - related racial misclassification project. This project quantifies the extent of racial misclassification of AI/AN in New Mexico state mortality records. Data from the New Mexico vital records database are matched against the Indian Health Service patient registry. Once the extent of racial misclassification is quantified, state mortality data can be better interpreted to accurately identify the leading causes of death among AI/AN in New Mexico.

Non-traffic Injuries and Alcohol in New Mexico Native Americans

Dr. Smelser (EIS/EPO) also undertook a project analyzing fatal non-traffic injuries involving alcohol in the American Indians in New Mexico. Unintentional injuries are the third leading cause of death in New Mexico, accounting for 7.1% of all deaths compared to 3.9% of all U.S. deaths. The extent to which these fatal non-traffic injuries involve alcohol is unknown. The project will determine the rate of fatal non-traffic injuries involving alcohol, compare the rate to the overall U. S. rate, and analyze case characteristics to identify high-risk groups. The results of this project will aid in targeting prevention efforts to high-risk populations in the state.

PHPPO

The PHPPO Academic Programs Office creates and sustains linkages between all CDC units and the academic communities of public health and preventative medicine, including the American Indian Health Education Consortium (AIHEC). A major focus is on mobilizing CDC-academia partnerships to address high priority prevention research needs. The Academic Programs Office also sponsors the annual "Partnering" conference and other forums for the exchange of ideas and research findings between public health practitioners and academic researchers, makes experimental opportunities available at CDC for young professionals, and provides strategic consultation to academic partner.

8. OTHER

Included in this section are examples of other CDC AI/AN-focused activities that are not covered in the seven categories above. Many of these activities fall under the broader categories of training, technical assistance, direct assistance, and workforce development.

NCCDPHP, Division of Adult and Community Health (DACH)

Cardiovascular Disease Prevention

NCCDPH continues to provide technical assistance in the implementation and evaluation of cardiovascular disease risk factor prevention and intervention programs to tribal communities. CDC continues to publish and disseminate lessons learned from the Inter Tribal Heart Project and to explore, develop, and implement surveillance and intervention strategies useful for tribal communities. In addition, activities include a focus on mapping the geographic disparities in heart disease and stroke mortality among American Indians and Alaska Natives.

NCCDPHP, Division of Adolescent and School Health (DASH)

School-based HIV Prevention

The Division of Adolescent and School Health, through a memorandum of agreement with the Bureau of Indian Affairs (BIA), supports training for BIA elementary school teachers to deliver an AI/AN-specific curriculum called the Circle of Life designed to provide young people with skills and information to avoid behaviors that put them at risk for HIV infection. The curriculum was developed through collaboration between the BIA, IHS, and CDC. In addition, ten states received supplemental funds to address HIV prevention among American Indian and Native American youth: California, Michigan, Minnesota, Montana, New Mexico, North Carolina, North Dakota, Oregon, Washington, and Wisconsin.

CDC is assisting the BIA in evaluating Circle of Life, a culture-based HIV/AIDS prevention curriculum for AI/AN children in grades K-6. This curriculum was developed by ORBIS Associates in the mid-1990s, under a contract with the IHS. The curriculum was developed because there was very little HIV prevention material available that was culturally-based, and appropriate for AI/AN youth. Circle of Life was designed and developed based on extensive formative research that included key informant interviews, focus group interviews, and pilot testing. Members of the Native community, health educators, practitioners, and teachers played an instrumental role throughout the development process.

NCCDPHP, Division of Cancer Prevention and Control (DCPC)

Comprehensive Cancer Control

In FY 2003, NCCDPHP continued the field assignment of a chronic disease medical epidemiologist to the IHS National Epidemiology Program in Albuquerque, NM to support IHS and tribal epidemiologic capacity for comprehensive cancer control. In addition to technical support and training, this physician-epidemiologist leads the cancer registry and racial misclassification efforts noted elsewhere in this document.

NCCDPHP, Division of Diabetes Translation (DDT)

Diabetes Prevention

CDC staff from DDT provide technical assistance to the Indian Health Service (IHS) Diabetes Program on surveillance of diabetes and diabetes–related complications among AI/AN. CDC works closely with IHS, documenting the large and disproportionate burden of diabetes in this population and the increasing trend in diabetes prevalence, particularly among young AI/AN. For example, CDC used data from the United States Renal Data System (USRDS) to document trends in incidence of treatment for diabetes-related end-stage renal disease. Results of CDC's work have been 1) used to report to Congress on the burden of diabetes among AI/AN, 2) used to allocate IHS diabetes grant funds, 3) disseminated to the IHS coordinators of diabetes prevention and control efforts, 4) posted on the website of the IHS Diabetes Program, and 5) included in the CDC National Diabetes Fact Sheet.

NCCDPHP, Division of Reproductive Health (DRH)

Reproductive Health

In FY 2003, an epidemiologist from the CDC PRAMS team provided training on PRAMS at Shiprock, NM. Several tribes from the Four Corners region were invited. The training was attended by members of the Navajo tribal administration and the medical center. Individual training on analyzing PRAMS data was provided for two epidemiologists.

NCCDPHP, Office on Smoking and Health (OSH)

Tobacco Control

OSH sponsored a training session for the Tribal Support Centers June 6-8, 2003, in Chicago, IL. This was a joint training for the CDC funded National Networks which includes the Native American National Network out of the Northwest Portland Area Indian Health Board. Also, provided ongoing technical assistance to the TSCs. They received funding to attend the annual Program Manger's Meeting as well as an AI/AN specific training held June 4-6, 2003, Chicago, IL. The TSCs are encouraged to attend regular CDC sponsored trainings such as the Tobacco Leadership Institute, formerly known as TUPTI, held in July 2003, and the National Conference on Tobacco or Health (NCTH) held in Boston, MA, December 2003. Finally, OSH co-sponsored the annual Native American Tobacco Use Prevention Conference, Nashville, TN, August 2003.

NCHSTP, Office of the Director (OD)

In-Kind Support

In fiscal year (FY) 2003, NCHSTP/OD maintained an intra-agency agreement with the Indian Health Service. This agreement details arrangements for technical assistance and consultation services to be provided to IHS by NCHSTP staff in the Office of Health Disparities and the Prevention Informatics Office. Under this agreement, NCHSTP staff managed a project to evaluate racial misidentification of AI/AN in state/county HIV/AIDS surveillance databases; conducted an analysis of surveillance systems for monitoring HIV/AIDS, sexually transmitted diseases (STDs), tuberculosis (TB) and viral hepatitis among AI/AN people; provided consultation on the development of an HIV Case Management System for use by IHS clinicians, and provided technical support for standardization of laboratory data to the accepted standard, Logical Observation Identifier Names and Codes (LOINC), and for data validation and evaluation of "ID Web," a web-based system to improve the quality of STD-related care. These activities are ongoing.

Since 2000, NCHSTP has supported a full-time Senior Epidemiologist in the Office of Health Disparities, who serves as liaison for AI/AN activities. NCHSTP has also partially supported the salary of a Senior CDC-Tribal Liaison for Science and Public Health, assigned from the CDC Office of Minority Health to the IHS National Epidemiology Program. In FY 2003, NCHSTP established a contractual arrangement with an AI/AN consultant to assist in identifying ways to improve AI/AN government's and organization's access to NCHSTP programs, and to better coordinate NCHSTP's public health activities and leverage resources to address AI/AN health disparities.

Regional Capacity Building Coordinators

In FY 2003, NCHSTP/DHAP and DSTDP funded capacity-building efforts in two IHS Administrative Areas, Navajo and Aberdeen. Arrangements have been made through existing contractual mechanisms and specific memoranda of agreement to place STD/HIV capacity building coordinators with tribal organizations (a Tribal Health Department and an Indian Health Board) serving these two Areas. The purpose of these arrangements is to leverage available resources for STD/HIV control through better coordination and outreach (linking agencies with resources with populations in need of services). The National Native American AIDS Prevention Center also receives support through a memorandum of agreement with the National Minority AIDS Council (funded by NCHSTP/DHAP) to provide technical assistance in infrastructure development to organizations working with AI/AN populations.

Fellowship and Internship Programs

NCHSTP supported five American Indians in fellowship or trainee programs in FY 2003. One was a physician who completed a Preventive Medicine residency. Two participated in CDC fellowship programs, and three participated in the American Indian Science and Engineering Society internship program. The trainees worked with doctoral-level scientists at CDC to gain experience using public health methodologies and tools to describe and address health disparities, particularly disparities related to HIV/AIDS, STDs, and TB among AI/AN populations.

Conference on Academic Needs

NCHSTP contributed funding for, and is participating in the development of, the conference, “Identifying the Academic Needs of American Indian, Alaska Native, and Native Hawaiian (AI/AN/NH) students to Pursue Careers in Public Health.” The purpose of this conference is to devise a plan that identifies and addresses the academic needs of AI/AN and Native Hawaiian (NH) students to pursue careers in Public Health. The specific objectives of this conference are to increase the number of AI/AN/NH public health professionals employed at CDC; to increase the number of AI/AN/NH students participating in CDC/ATSDR trainings, internships, and fellowships; and to increase the number of AI/AN/NH public health professionals.

Development of a Tribal College Public Health Program

In FY 2003, NCHSTP continued support for the development of a public health program at Dine’ Community College, in collaboration with the Arizona College of Public Health. Dine’ College is the first tribal college and is known as the “higher education institution of the Navajo.” Dine’ College enrolls approximately 2,000 students. The development of the Dine’ College-Arizona College of Public Health Joint Certificate and Degree Programs includes continuing education/ certificate courses, a 1-year Public Health Sciences Certificate, and an Associate of Science Public Health Program. The continuing education/certificate courses and the 1-year Public Health Sciences Certificate are training programs for Community Health Representatives, who are a vital link in the American Indian health care system. The Public Health Program is designed to provide a culturally supportive atmosphere for training in a multicultural approach to public health.

NCHSTP, Division of STD Prevention (DSTDP)

Intra-agency Agreement with the Indian Health Service

In FY 2003, NCHSTP/DSTDP supported an intra-agency agreement with the IHS. This agreement provides staff to the IHS Epidemiology Program, and technical assistance to IHS tribal and urban health facilities. Activities included: site visits to enhance partnerships among agencies that provide STD services to AI/AN persons; fiscal and staff support for the “Stop Chlamydia!” program; management of ID Web, a web-based STD quality-of-care improvement and training project in 5 facilities; and a training needs assessment for public health workers. These projects, and the Comprehensive STD Prevention Systems Grant Program, are discussed further in the sections below.

STD Prevention Training for Public Health Workers

Under an intra-agency agreement with the IHS, NCHSTP/DSTDP-Funded Prevention Training Centers conducted an assessment of training needs of health care providers that resulted in the provision of six STD training sessions at IHS facilities. The Prevention Training Centers also developed customized training for Disease Intervention Specialists for Navajo Nation Social Hygiene Program Personnel and Public Health Nurses working at an Indian Reservation in Montana.

NCHSTP, Division of Tuberculosis Elimination (DTBE)

TB Control Activities

NCHSTP/DTBE funding supports activities targeting AI/AN populations in cooperative agreements with States, Cities and Territories to promote tuberculosis (TB) elimination efforts. In 2003, DTBE provided on-site emergency technical, programmatic, and financial assistance to Seattle-King County Public Health/TB Control to investigate a TB outbreak among homeless persons, half of whom were American Indians or Alaska Natives.

Building Capacity for TB Control in Low Incidence States

NCHSTP/DTBE is collaborating with IHS on TB control initiatives in low incidence states, where most AI/AN persons diagnosed with TB reside. The goal of this effort is to identify models for regional capacity-building, which would encompass Federal, State, and Tribal TB control programs.

NCID, Division of Vector-Borne Infectious Diseases (DVBID)

DVBID frequently responds to requests from IHS to provide diagnostic and on-site epidemiologic assistance during plague case investigations on AI/AN lands in this region. In recent years, DVBID has also provided training to IHS staff on plague surveillance, control and diagnosis. This training has been provided during plague case investigations, in small on-site sessions involving just a few persons, and in larger workshops presented to staff attending regional IHS meetings.

Recently, DVBID participated in the investigation of a tick-borne relapsing fever outbreak that occurred on the Navajo Reservation in New Mexico. During this outbreak DVBID staff members traveled to the suspected exposure site to assess ongoing risks and make prevention recommendations. Other DVBID staff members provided valuable diagnostic support for the investigation.

NCID, Office of Minority and Women's Health (OMWH)

OMWH increased participation in outreach activities targeting AI/AN students. Outreach activities included recruitment events, and public health conferences for the purpose of providing employment and public health information to students, faculty, and the AI/AN community. In addition to outreach activities, OMWH funded one American Indian Science and Engineering Society (AISES) intern slot. We also had one American Indian participate in the James A. Ferguson Fellowship Program.

NCIPC

In Kind Support

In FY 2003, NCIPC maintained an intra-agency agreement with the Indian Health Service (IHS). This agreement details arrangements for an IHS Epidemiologist to be assigned to the Division of Unintentional Injury Prevention. The Epidemiologist provides technical assistance and consultation services to IHS, and Tribal organizations working in injury prevention and control. Under this agreement, the assignee participated in a project to understand risk and protective factors for self-directed violence and weapon carrying among urban American Indian youth, and on projects to distribute smoke alarms for prevention of fire-related injuries among high risk communities, including residences on Indian reservations.

The assignee collaborated with the IHS on an Atlas of Injuries Among

Native American Children which focused on the eight leading causes of injury; assisted the United Tribes Technical College's Associate Degree program in Injury Prevention for Native American students; and helped revise and teach the week-long Introduction to Injury Prevention training course used to educate IHS and Tribal staff about community-based injury prevention. This course, conducted since 1985, has trained hundreds of IHS and tribal staff members in basic injury prevention practice. These activities are ongoing (see also the article on injury mortality cited in section #7 above).

NIOSH

During FY 2003, NIOSH committed to providing program and financial support to the first conference on increasing American Indian/Alaska Native/Native Hawaiian (AI/AN/NH) careers in Public Health: "Identifying the Academic Needs of AI/AN/NH students to Pursue Careers in Public Health." The conference will be held in Atlanta, Georgia during the summer of 2004. The specific objectives of this conference are to increase the number of AI/AN/NH public health professionals employed at CDC; increase the number of AI/AN/NHs participating in CDC/ATSDR training/ internship/fellowship programs; and increase the number of AI/AN/NH public health professionals.

EPO

Epi Info Training for the Indian Health Service - (White River, AZ)

The Division of Public Health Surveillance and Informatics (DPHSI), Epidemiology Program Office (EPO) is working on the details for a collaborative effort with Indian Health Service to conduct an Epi Info, software for public health, training workshop in White River, Arizona. The training session will occur in late winter and will take place over two days. The Epi Info training will train American Indian health professionals in the use of the software including how to develop surveillance on health problems or issues and perform analysis on the data generated. The "Train-the-Trainer" format will generate opportunities for those trained at this workshop to go out and train additional public health professionals to benefit from the use of *Epi Info.*

OD, OTPER

OTPER staff is assisting the CDC/NCEH/Public Health Emergency Preparedness Branch Working Group in developing an emergency response guide for state, local and tribal public health officials. This guide will be an easy-to-use-all-hazards public emergency response guide that tribal public health officials who are responsible for initiating the public health response during an emergency or disaster so that they may have immediate access to information and guidance for rapidly establishing priorities and undertaking necessary actions to prevent injury, save lives, and mitigate adverse health effects. It will also contain tribal incident-specific public health response recommendations and guidelines that are applicable to specific types of emergencies or disasters (e.g., power outages, earthquakes, hurricanes, tornados, floods, terrorism, chemical/hazardous substances releases, etc.) A two day consultancy forum will be held in Louisville, KY in January 2004 in which several tribal representatives who have been identified will participate to have an opportunity to offer comments, suggestions, and information for potential inclusion in the Guide. A draft version of the Guide will be completed and ready for distribution for Tribal review and comment by 04/04.

In FY 03 OTPER staff has been assisting in the development of a

conference, to be held in 2004, titled “Identifying the Academic Needs of American Indian, Alaska Native, and Native Hawaiian (AI/AN/NH) students to Pursue Careers in Public Health.” The purpose of this conference is to devise a plan that identifies and addresses the academic needs of AI/AN and Native Hawaiian (NH) students to pursue careers in Public Health. The specific objectives of this conference are to increase the number of AI/AN/NH public health professionals employed at CDC; to increase the number of AI/AN/NH students participating in CDC/ATSDR trainings, internships, and fellowships; and to increase the number of AI/AN/NH public health professionals.

OTPER staff supports and is providing on-going consultation to Tribes on the Cooperative Agreement 99051, including conducting tribal site visits and conducting several National presentations on AI/AN bioterrorism and emergency response initiatives at annual State BT conferences.

OTPER staff provided support and assisted ATSDR and EPA in a Pilot Emergency Response Survey. This is an assessment tool to identify tribal preparedness capabilities for chemical, biological, and radiological emergencies. OTPER assisted ATSDR staff on a site visit to the Tohono O’Odham Nation in Arizona. This site was one of several selected for the survey due to proximity of air, rail and auto transportation routes, industrial and commercial business on and near the nation, use of military fly-overs (with occasional crashes), and border issues which could lead to chemical and/or bio-terrorism concerns.

OTPER staff is involved with NCEH staff in the development of strategies to increase tribal participation in evidence-based scenarios and table-top exercises for all-hazards preparedness.

OTPER staff assisted OD staff on Border funding/programmatic issues with tribal governments. With funding and coordination provided by the OASPHEP, CDC is building the capacity of public health agencies representing border counties and tribes to participate in intra-US and cross-border collaborative activities. CDC was awarded $4 million to be allocated to 20 states that border Mexico and Canada. Each selected state is being asked to submit a proposal that will include a brief description of not only planned, but also current border-related activities and the proposed allocation of funds for these activities.

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PART III:

BUDGET SUMMARY FOR RY 2002, 2003, AND 2004 REQUEST

FY 2002

Program or Budget Activity	Budget Amount
Epidemiology Program Office	$137,000
National Center on Birth Defects and Developmental Disabilities	$223,739
National Center for Chronic Disease Prevention and Health Promotion	$21,379,286
National Center for Environmental Health	$573,000

National Center for Health Statistics	$0
National Center for HIV, STD, and TB Prevention	$5,840,930
National Center for Infectious Diseases	$2,944,000
National Center for Injury Prevention and Control	$212,114
National Immunization Program	$131,496
National Institute for Occupational Safety and Health	$1,152,126
Office of the Director	$0
Public Health Practice Program Office	$1,332,824
TOTAL	**$33,939,048**

NOTE: Between FY 2002 and FY 2003, CDC improved its ability to track funds serving AI/AN populations. Changes in budget amounts noted between FY 2002 and FY 2003 reflect both actual changes in AI/AN program funds and improved reporting. The figures reported for FY 2003 and FY 2004 reflect direct grants to tribes and tribal organizations, grants to states and academic institutions that primarily benefit AI/AN populations, federal intra-agency agreements (primarily with IHS), and intramural funds supporting CDC staff that work exclusively or predominantly on AI/AN health. With the exceptions of the budgets for the National Immunization Program and the National Center for Health Statistics, the FY 03 and FY 04 tables do NOT include indirect funding streams that may benefit AI/AN populations. Examples of such indirect funds are grants/cooperative agreements to state and local health departments whose jurisdictions include AI/AN communities and grants/cooperative agreements to academic and other institutions whose funded activities may benefit AI/AN populations in some way. Because indirect funds may have been included in past tables, some programs (e.g., the National Institute for Occupational Safety and Health) may appear to have decreased resources, which is not necessarily the case. As CDC continues efforts to improve its ability to more accurately track dollars that benefit AI/AN populations, future tables will include these indirect funding streams.

FY 2003	
Program or Budget Activity	**Budget Amount**
Epidemiology Program Office	$333,462
National Center on Birth Defects and Developmental Disabilities	$475,000
National Center for Chronic Disease Prevention and Health Promotion	$24,379,286
National Center for Environmental Health	$604,233
National Center for Health Statistics[1/]	$1,201,461
National Center for HIV, STD, and TB Prevention	$3,053,551
National Center for Infectious Diseases	$3,366,645

National Center for Injury Prevention and Control	$120,000
National Immunization Program	$24,459,777
National Institute for Occupational Safety and Health	$92,000
Office of the Director	$646,061
Public Health Practice Program Office	$1,319,639
TOTAL	**$60,051,116**

[1]/These funding levels are based on reasonable estimates of the population served.

FY 2004 REQUEST	
Program or Budget Activity	**Budget Amount**
Epidemiology Program Office	$333,362
National Center on Birth Defects and Developmental Disabilities	$475,000
National Center for Chronic Disease Prevention and Health Promotion	$24,379,286
National Center for Environmental Health	$604,233
National Center for Health Statistics[1/]	$1,202,461
National Center for HIV, STD, and TB Prevention	$3,053,551
National Center for Infectious Diseases	$3,366,645
National Center for Injury Prevention and Control	$120,000
National Immunization Program	$24,459,777
National Institute for Occupational Safety and Health	$92,000
Office of the Director	$668,407
Public Health Practice Program Office	$1,319,639
TOTAL	**$60,073,462**

[1]/These funding levels are based on reasonable estimates of the population served.

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PART IV:

INTRADEPARTMENTAL COUNCIL ON NATIVE AMERICAN AFFAIRS PRINCIPAL INITIATIVES:

1. INCREASE NATIVE AMERICAN ACCESS TO EXISTING AND NEW HHS PROGRAMS

Tribal governments and tribal organizations are broadly eligible for many CDC grants and programs. Some specific examples from the Centers for Disease Control and Prevention's (CDC) CIOs (Centers, Institute, and Offices) are cited below:

Office of the Director (OD)

In June 2003, the Office of Terrorism Preparedness and Emergency Response (OTPER) added a position in the State and Local Preparedness Program (SLPP) that is serving as the tribal liaison officer. OTPER recognizes the critical role of AI/AN communities in the nation's effort to be better prepared for terrorism and other public health emergencies. This individual's duties include being responsible for the oversight, review, and summarization of Bioterrorism (BT) and Emergency Response tribal activities across the country, related to CDC's BT Cooperative Agreement 99051. Although no funds are appropriated through CDC to directly fund tribal governments, CDC strongly encourages each state BT office to provide on-going funds to their respective tribes. In a continuing process, a number of tribes have received contractual funds through their state BT program for implementation of Tribal BT initiatives.

National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

Steps to a HealthierUS

The *Steps to a HealthierUS* Cooperative Agreement Program 2003 Request for Assistance (RFA) included set-aside funding for a tribal consortia. Through this funding mechanism, the Inter-tribal Council of Michigan was funded to implement community-focused initiatives to reduce the burden of asthma, diabetes, and obesity.

Smoking and Health

In FY 2000, CDC's Office on Smoking and Health released Program Announcement 00065 for tobacco control and prevention capacity building with AI/AN tribes, tribal organizations, and urban populations. A total of $1.6 million was distributed among seven projects. Grantees include Aberdeen Area Tribal Chairmen's Health Board, Alaska Native Health Board, California Rural Indian Health Board, Intertribal Council of Arizona, Muscogee Creek Nation, Intertribal Council of Michigan and Northwest Portland Area Indian Health Board. The grantees are beginning their fourth year of program implementation (of five year program.) In addition to the funding, CDC supports these programs with training, technical assistance, and other needs.

Supplements to support AI/AN version of the Adult Tobacco Survey (ATS) Pilot Study awarded to six of seven Support Centers. The ATS is a random survey of adults' tobacco use knowledge, attitudes, and behaviors. In FY 2003, over $3 million was made available to fund nine organizations serving different population groups (Program Announcement 00085) for the development of national tobacco control networks. The Northwest Portland Area Indian Health Board was funded to serve the AI/AN populations.

Cancer Prevention and Control

Eligibility requirements for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and the National Comprehensive Cancer Control Program (NCCCP) include all federally recognized Indian tribal governments and tribal organizations, urban Indian organizations and inter-tribal consortia whose primary purpose is to improve American Indian/Alaska Native health and which represent the Native population in their catchment area (Program Announcement #02060). Every year, a competitive open season for application to these programs is announced in the *Federal Register* along with call-in information for technical assistance conference calls to assist potential applicants in understanding the application process, scope, and nature of the programs.

Nutrition and Physical Activity

Tribes are eligible to apply for funding for CDC's Well-Integrated Screening and Evaluation for Women across the Nation (WISEWOMAN) program, which is authorized under CDC's National Breast and Cervical Cancer Early Detection Program.

National Center for HIV, STD, and TB Prevention (NCHSTP)

In 2003, the NCHSTP improved AI/AN governments and organizations' access to HHS grants by including them as eligible applicants in two new competitive cooperative agreement announcements. Federally recognized tribal governments are eligible to apply for funding under the first announcement, "Evaluation of Web-based HIV Risk Behavior Surveillance among Men Who Have Sex with Men," which is responsive to *Healthy People 2010* objectives 13-6 and 25-11. Federally recognized Indian tribal governments, Indian tribes, and Indian tribal organizations are eligible to apply under the second announcement, "HIV Conference Support."

National Center for Infectious Diseases (NCID)

In 2003, NCID improved AI/AN governments and organizations access to grants and research projects enabling NCID AIP to continue to conduct surveillance, epidemiologic and laboratory research, prevention projects, training and information dissemination concerning infectious diseases/conditions that impact Alaska Native and other Arctic residents to include programs focusing on prevention of Pneumococcal Disease in Alaska Native Elders.

In 2002, NCID Division of Viral Hepatitis (DVH) provided $50,000 to Salish Kootenai College to develop materials and approaches to educate Indian Health Service and tribal health providers, AI/AN community health representatives, and public health nurses to integrate viral hepatitis counseling, testing, immunization, prevention and clinical services into STD and HIV prevention and treatment services and settings. NCID/DVH also funds three tribal organization-based Viral Hepatitis Integration Projects in Arizona, New Mexico, and Washington; two new sites were added in FY 2003 in Alaska and Montana.

In 2003 and 2002, NCID's Minority and Women's Health increased participation in outreach activities targeting AI/AN students. Outreach activities included recruitment events and women's health conferences for the purpose of providing employment and public health information to students, faculty, and the AI/AN community. In addition to increasing outreach to AI/AN students for all NCID student opportunities, NCID specifically funded a slot for an American Indian Science and Engineering Society (AISES) student fellowship.

National Institute for Occupational Safety and Health (NIOSH)

Indian tribes, tribal governments, and tribal colleges and universities are institutions eligible for NIOSH grant announcements.

2. INCREASE HHS RESOURCES FOR TRIBES AND NATIVE ORGANIZATIONS

Steps to a HealthierUS

Increased funding, as requested in the FY 2005 budget, would allow the *Steps to a HealthierUS* Cooperative Agreement Program to fund current tribal consortia at higher levels and increase the number of tribes that receive funding (an average award of $650,000 for up to 3 additional tribes).

Cancer Prevention and Control

CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) has helped to increase mammography use by women aged 50 years and older by 20 percent since the program's inception in 1991. NBCCEDP targets low-income women with little or no health insurance and has helped reduce disparities in screening for women from racial and ethnic minorities. Approximately 50 percent of screenings provided by the program were to women from racial or ethnic minority groups. Of that 50 percent, approximately 6.8 percent are AI/AN women.

The President's budget proposes an increase in FY 2005 for the NBCCEDP. This increase would yield more women, including AI/AN, being screened for these cancers. Under Program Announcement #02060, tribes and tribal organizations would be eligible to apply for funding to provide these screening services; the open season competition is expected to be released early next spring. The increased support will also allow CDC to potentially increase the number of tribes or tribal organizations that will receive financial assistance.

3. DESCRIBE ANY OTHER INITIATIVES OR SPECIAL EFFORTS UNDERTAKEN BY YOUR DIVISION TO IMPROVE HEALTH AND HUMAN SERVICES FOR NATIVE AMERICAN TRIBAL GOVERNMENTS AND INDIAN ORGANIZATIONS

Listed below, and categorized by CIO, are a number of relevant examples of initiatives and special efforts undertaken by CDC to improve public health for Native American tribal governments and Indian organizations.

Office of the Director (OD)

OMH is also partnering with NCHSTP by supplementing their cooperative agreement with the National Native American AIDS Prevention Center (NNAAPC) in planning CDC/ATSDR's 1st Conference on Increasing American Indian/Alaska Native/Native Hawaiian (AI/AN/NH) Careers in Public Health. This national conference is being planned for June 2004 with the purpose of developing a plan that identifies and addresses the academic needs of AI/AN/NH students to pursue careers in public health. The specific objectives of this conference are to increase the number of AI/AN/NH public health professionals employed at CDC; to increase the number of AI/AN/NHs participating in CDC/ATSDR trainings internships/ fellowships; and increase the number of AI/AN/NH public health professionals.

National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

Office on Smoking and Health

The Office on Smoking and Health (OSH) Program Services Branch staffs a field assignee at the Indian Health Service, National Epidemiology Program, in Albuquerque, New Mexico, to provide technical assistance and consultation to tribes, tribal and urban organizations. OSH has also begun the process aimed at developing a cessation guide for AI/AN communities. The guide will be modeled after the Pathways to Freedom guide for African American communities, a cultural approach to educating, planning and organizing communities around tobacco use cessation.

Division of Adult and Community Health (DACH)

The Cardiovascular Health Branch, in collaboration with IHS, provides technical assistance in the implementation and evaluation of cardiovascular disease risk factor prevention and intervention programs to tribal communities. The branch continues to publish and disseminate lessons learned from the Inter Tribal Heart Project and to explore, develop, and implement surveillance and intervention strategies useful for tribal communities. In addition, branch activities include a focus on mapping the geographic disparities in heart disease and stroke mortality among AI/ANs.

Division of Reproductive Health (DRH)

Assignment of DRH Field Assignees
Leslie Randall is a DRH assignee to the National IHS Epidemiology Program in Albuquerque, New Mexico. Ms. Randall provides technical consultation and assistance to federal, state, tribal, local and other health agencies concerning various epidemiology projects. She works through a Memorandum of Agreement between IHS and CDC, on Reproductive Health/Behavioral Risk Surveys and provides technical assistance for the design, implementation, analysis, training and dissemination of findings to the tribes. This past year, Ms. Randall provided assistance to Rosebud Sioux Tribe on reproductive health issues. She has given many national presentations on infant health and interviews on SIDS with the Associated Press, National Native Calling, National Native News, and many local newspapers. Ms. Randall also provided technical assistance to the project officer for the Tobacco Support Centers funded through the Office of Smoking and Health for the survey instrument and the IHS Institutional Review Board. In addition, Lori de Ravello is assigned to NCHSTP in Albuquerque. She receives 60 percent of her support from DRH to facilitate work on American Indian Maternal and Child Health issues.

National Center for HIV, STD, and TB Prevention (NCHSTP)

In 2003, NCHSTP also took the following steps to improve Native American governments and organizations access to HHS programs:

- 1) establishment of a contractual arrangement with a Native American consultant to assist in identifying ways to better coordinate NCHSTP's public health activities and leverage resources to address AI/AN health disparities; and
- 2) establishment of three contractual positions to build regional capacity in two IHS areas (Navajo, Aberdeen) to prevent and control sexually transmitted diseases, including HIV.

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